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Nos. 84-1353, 84-1354

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

JAMES P. KARTELL, HERBERT W. HORNE, JR. and HARRY D. WILSON, JR.,

Petitioners,

v.

BLUE SHIELD OF MASSACHUSETTS, INC.,

Respondent.

GRANT V. RODKEY, M.D., HENRY BROWN, M.D., and THE MASSACHUSETTS MEDICAL SOCIETY,

Petitioners,

v.

BLUE SHIELD OF MASSACHUSETTS, INC.,

Respondent.

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

MOTION OF AMERICAN MEDICAL ASSOCIATION FOR LEAVE TO FILE BRIEF AMICUS CURIAE AND BRIEF AMICUS CURIAE IN SUPPORT OF PETITIONERS

Of Counsel:
KIRK B. JOHNSON
B. J. ANDERSON
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
(312) 645-5000

NEWTON N. MINOW
JACK R. BIERIG*
JEFFREY R. TONE
Sidley & Austin
One First National Plaza
Chicago, Illinois 60603
(312) 853-7000

Counsel for Amicus Curiae American Medical Association
* Counsel of Record

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MOTION OF AMERICAN MEDICAL ASSOCIATION FOR LEAVE TO FILE BRIEF AMICUS CURIAE

The American Medical Association respectfully requests that it be granted leave to file a brief amicus curiae in support of petitioners. The brief is submitted herewith.

In support of this motion, the Association states as follows:

1. Consent was sought from petitioners and respondent for the filing of a brief amicus curiae in support of petitioners. Petitioners consented, but respondent did not. A copy of petitioners' letters of consent is reproduced in the Appendix to the Brief Amicus Curiae.

2. The Association is the oldest and largest national organization of physicians in the United States. It had 254,000 physician members at the end of 1983.

3. Many of the Association's members in Massachusetts are directly affected by the ban on balance billing at issue in this case.

4. If the decision of the Court of Appeals is allowed to stand, these physicians will be victims of a practice which, as the district court found, discourages the use of "the safer, innovative, relatively inexpensive procedure." *Kartell* v. *Blue Shield of Massachusetts*, 582 F. Supp. 734, 752-53 (D. Mass.), *aff'd in part, rev'd in part and vacated in part*, 749 F.2d 922 (1st Cir. 1984). In addition, the First Circuit's decision has significance beyond Massachusetts. If that decision is not reversed, other Blue Shield plans in other states will be encouraged to impose similar bans—with similar adverse effects.

5. Furthermore, the decision of the Court of Appeals has nationwide ramifications with respect to the antitrust significance of other cost-control mechanisms introduced by insurers. These mechanisms will have a direct impact on the members of the Association.

6. As a national organization dedicated to fostering the advancement of medical science and the health of the American people, the Association offers an important perspective on the issues before the Court. The Association

therefore submits its brief amicus curiae in order to present its thoughts on why the decision of the Court of Appeals does not permit proper scrutiny of the competitive significance of the challenged ban. The Association also seeks to explain why the ban suppresses competition and why its elimination will promote competition, enhance consumer welfare, and encourage innovation and good medical care.

CONCLUSION

The Association respectfully requests that this Court grant it leave to file the brief amicus curiae submitted herewith.

Respectfully submitted,

NEWTON N. MINOW
JACK R. BIERIG
JEFFREY R. TONE
SIDLEY & AUSTIN
One First National Plaza
Chicago, Illinois 60603
(312) 853-7000
Counsel for Amicus Curiae American Medical Association

Of Counsel:
KIRK B. JOHNSON
B. J. ANDERSON
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
(312) 645-5000

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ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

BRIEF OF AMERICAN MEDICAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

INTEREST OF AMICUS CURIAE

This brief is submitted by the American Medical Association in support of petitioners.[1] Founded in 1846, the

[1] The filing of this brief was consented to by all petitioners but not by respondent. A copy of petitioners' letters of consent is reproduced in the Appendix hereto. In accordance with Supreme Court Rule 36, this brief is submitted with the Motion of American Medical Association for Leave to File Brief Amicus Curiae.

Association is the oldest and largest national organization of physicians in the United States. At the end of 1983, it was comprised of over 254,000 physicians.

The Association and its members have a direct interest in the issues raised by petitioners. Initially, many of the Association's members in Massachusetts are immediately affected by respondent Blue Shield's ban on balance billing. If the decision of the Court of Appeals is allowed to stand, these physicians will be victims of a practice which discourages them "from undertaking the training and purchasing the equipment necessary to learn and offer the safer, innovative, relatively inexpensive procedure." *Kartell v. Blue Shield of Massachusetts*, 582 F. Supp. 734, 752-53 (D. Mass.), *aff'd in part, rev'd in part and vacated in part*, 749 F.2d 922 (1st Cir. 1984).

More generally, the First Circuit's decision in this case has significance beyond Massachusetts. If the decision is not reversed, Blue Shield plans in other states will be encouraged to impose similar bans—at least where they have sufficient market power to do so. Thus, the adverse effects on competition and on quality of care found by the district court will spread to other states.

Finally, the decision has nationwide ramifications in a number of different contexts not directly related to a ban on balance billing. As pressures to reduce health care costs intensify, insurers throughout the country can be expected to introduce a variety of cost-control mechanisms. These mechanisims will have a major effect on the delivery of medical care by physicians. Some of these mechanisms, *e.g.*, preferred provider organizations (PPOs), are generally pro-competitive.[2] Others, *e.g.*, PPOs with market dominance

[2] In a PPO, the insurer and provider agree on the maximum charge that the provider will make to PPO subscribers. In return, the insurer offers financial incentives to induce patients to use the "preferred provider." Most PPOs also have effective programs of utilization review.

and exclusivity agreements, may be anti-competitive. *See Jefferson Parish Hospital District No. 2* v. *Hyde*, —— U.S. ——, 104 S.Ct. 1551 (1984).

Under the decision of the Court of Appeals, these cost-control mechanisms will be virtually immunized from anti-trust scrutiny regardless of their competitive significance. They will be justified simply because they are imposed by an insurer who is viewed as a purchaser of services. The effect of this development will be to permit anticompetitive conduct that leads to inferior medical care.

As a national organization dedicated to fostering the advancement of medical science and the health of the American people, the Association offers an important perspective on the issues before the Court. It respectfully submits this brief amicus curiae in order to present its thoughts on why the decision of the Court of Appeals does not permit proper scrutiny of the competitive significance of the challenged ban and of other restraints imposed by insurers. The Association also seeks to explain why the ban on balance billing suppresses competition and why elimination of the ban will promote competition and enhance consumer welfare.

Specifically, giving physicians the freedom to choose whether to accept an insurer's coverage as full payment for services promotes competition among physicians on the basis of price. This freedom will ultimately reduce the cost of health care. It will, moreover, enable physicians who do not accept the insurer's award as full payment to compete on the basis of quality of service. Thus it will encourage innovation and good medical care.

STATEMENT OF THE CASE

At issue in this case is Blue Shield's practice of prohibiting physicians from collecting the difference between their actual charge for a procedure and the amount reimbursed by Blue Shield for that procedure. As both lower courts agreed, the facts relating to this "ban on balance billing" are " 'not . . . generally . . . disputed.' " Petitioners' Appendix at 4 (hereinafter cited as "App."). These facts are set forth in detail in the two petitions.

In essence, however, the relevant facts can be reduced to five basic points:

1. Blue Shield of Massachusetts, Inc. is a medical service corporation which dominates the market for health insurance in Massachusetts. Blue Shield insures 3.2 million people, roughly 56 percent of the population of the Commonwealth and nearly three quarters of the privately insured population. The Court of Appeals stated that it "assume[d] that Blue Shield possesses significant market power." App. 11.

2. Blue Shield makes no payment for services performed by a physician who does not participate in its plan—except for emergency or out-of-state services. Notably, Blue Shield of Massachusetts is virtually unique among Blue Shield plans in the United States in this respect.

3. Blue Shield's dominant market share and refusal to pay for the services of non-participating physicians combine to force Massachusetts physicians to participate in the Blue Shield plan. The district court found that "doctors must accept defendants' pricing terms in order to maintain a viable practice . . . " 582 F. Supp. at 749. Not surprisingly, therefore, 99 percent of Massachusetts physicians in fee-for-service practice participate in the Blue Shield plan.

4. By virtue of payment practices adopted in 1977, the amounts paid by Blue Shield to participating physicians are substantially lower than physicians'

charges. In 1983, the difference between Blue Shield payments and the charges submitted by physicians was 103 million.

5. Blue Shield prohibits participating physicians from charging patients the difference between the actual charge for a procedure and the amount paid by Blue Shield. Thus, every physician must accept as payment in full the amount paid by Blue Shield. The physician is foreclosed from billing the patient for the balance of his or her charge even though this balance might reflect a difference in skill, experience, or accessibility.

The Court of Appeals did not disturb the district court's findings with respect to any of these facts. Rather, it held that on these facts, there was no "restraint" at all. App. 5. It concluded that "[t]he persuasive power of the district court's analysis disappears . . . once one looks at Blue Shield, not as an inhibitory 'third force' but as itself the purchaser of the doctors' services." App. 6. Viewing Blue Shield as merely a buyer, the Court held that the ban on balance billing is presumptively valid, because "[a]ntitrust law rarely stops the buyer of a service from trying to determine the price or the characteristics of the product that will be sold." Id.

The Court then considered whether Blue Shield's "significant market power" should rebut the presumption that its actions as a buyer are valid. App. 10. It concluded that Blue Shield's market power makes no "significant legal difference" at least as long as the insurer's prices are "below incremental cost." App. 11-12. In support of this conclusion, the Court cited no precedent dealing with section 1. Instead, it relied exclusively on monopolization cases under section 2 of the Sherman Act.

Having already concluded that the ban on balance billing is not a restraint at all, the Court turned to the specific

anticompetitive effects of the ban. It summarily dismissed these effects by observing that, as a buyer, Blue Shield can pay whatever it chooses for physicians' services. It then went on to consider various public policy arguments which it regarded as militating in favor of the ban. App. 18-20.

REASONS FOR GRANTING THE PETITION

I. THE DECISION OF THE COURT OF APPEALS CONFLICTS WITH EVERY DECISION OF THIS COURT WHICH HAS SET FORTH THE PROPER ANALYSIS UNDER THE RULE OF REASON.

The decision of the Court of Appeals conflicts directly and fundamentally with an unbroken line of cases which sets forth the proper analysis under the Rule of Reason. *National Collegiate Athletic Association* v. *Board of Regents*, ___ U.S. ___, 104 S.Ct. 2948, 2982 (1984); *National Society of Professional Engineers* v. *United States*, 435 U.S. 679, 691 (1978); *Continental T.V. Inc.* v. *GTE Sylvania, Inc.*, 433 U.S. 36, 49 (1977); *Chicago Board of Trade* v. *United States*, 246 U.S. 231, 238 (1918). These cases uniformly teach that "the inquiry mandated by the Rule of Reason is whether the challenged agreement is one that promotes competition or one that suppresses competition." *Professional Engineers, supra*, 435 U.S. at 691. In undertaking this inquiry, a court must consider "the facts peculiar to the business, the history of the restraint and the reasons why it was imposed." *Id.* at 692. *See also Copperweld Corp.* v. *Independence Tube Corp.*, ___ U.S. ___, 104 S. Ct. 2731, 2741 (1984) (The Rule of Reason mandates "an inquiry into market power and market structure designed to assess . . . actual effect" on competition); *Board of Trade, supra*, 246 U.S. at 238 (A court must consider "the nature of the restraint and its effect, actual or probable").

Under the Rule of Reason, the "purpose of the analysis is to form a judgment about the competitive significance of the restraint." *Professional Engineers, supra*, 435 U.S. at

692. The Court of Appeals, however, did not even attempt to analyze the competitive significance of the challenged ban on balance billing. It made no effort to evaluate the competitive effects of the ban in light of Blue Shield's market dominance and other facts peculiar to the delivery of physicians' services in Massachusetts. Rather, as far as the Court of Appeals was concerned, "[t]he relevant antitrust facts are that Blue Shield pays the bill and seeks to set the amount of the charge." App. 10. It would be difficult to imagine a clearer deviation from the inquiry into competitive effects mandated by relevant precedent of this Court.

The Court of Appeals considered itself free to dispense with any analysis of the competitive significance of the challenged restraint based entirely on its conclusion that Blue Shield was "the purchaser of the doctors' services." App. 6. The conclusion that Blue Shield is a buyer of services led the Court to make no assessment of the impact of Blue Shield's market power on competitive conditions—as required by *Copperweld, Professional Engineers,* and similar cases. Instead, the Court confined its consideration of Blue Shield's market dominance to an abstract discussion of whether a buyer's market power can overcome the presumption that the buyer may determine the price or characteristics of the product that will be sold.

For the same reason, the Court of Appeals dismissed in a single sentence petitioners' contentions regarding the anticompetitive nature of the challenged ban. Specifically, petitioners argued that, given Blue Shield's market dominance, the ban virtually eliminated price competition among physicians, reduced competition on the basis of quality, and discouraged market entry by new physicians. App. 15. Even though the district court had found these arguments dispositive, the entire "analysis" by the Court of Appeals was as follows: "The short—and conclusive—answer to these

arguments is that normally the choice of what to seek to buy and what to offer to pay is the buyer's." App. 16.

In short, the Court of Appeals substituted application of the "purchaser" label for analysis of competitive significance. Nothing in section 1 of the Sherman Act, however, permits justification of challenged conduct on the basis of defendant's status rather than inquiry into the competitive effects of defendant's conduct. On the contrary, after *Professional Engineers, Board of Trade,* and similar cases, the "purchaser" label should be of little relevance for purposes of Section 1 analysis.[3] Indeed, this Court has carefully scrutinized the competitive effects of purchase contracts. *See, e.g., Fortner Enterprises, Inc.* v. *United States Steel Corp.,* 394 U.S. 495 (1969); *Tampa Electric Co.* v. *Nashville Coal Co.,* 365 U.S. 320 (1961).

Antitrust claims should not be determined on the basis of an "'artificial distinction' at the expense of substance." *Copperweld, supra,* 104 S.Ct. at 2743. Any departure from the Rule of Reason should be "based upon demonstrable economic effect rather than . . . upon formalistic line drawing." *Sylvania, supra,* 433 U.S. at 58-59. Under the Rule of Reason, the question remains "whether or not

[3] In any event, reliance on the "purchaser" label as the basis of decision is particularly inappropriate on the facts of this case. It is, of course, true that Blue Shield indemnifies the patient for physicians' fees. But it is the patient who selects the physician, who agrees with the physician on the nature and extent of services performed, and who benefits from the treatment. Moreover, Blue Shield's contract with insureds provides that nothing therein shall "interfere with the normal relationship that exists in the community between a physician . . . and his patient." Thus, the First Circuit's characterization of Blue Shield as the purchaser of physicians' services is highly questionable. At most, it is accurate only to a point. In these circumstances, invocation of the "purchaser" label confounds rather than enlightens.

the challenged restraint enhances competition." *NCAA*, *supra*, 104 S.Ct. at 2982—not whether or not the defendant can be viewed as a purchaser.

In this respect, it is noteworthy that the only Supreme Court precedent cited by the Court of Appeals in support of its point that Blue Shield is a purchaser of services was *Group Life & Health Insurance Co.* v. *Royal Drug Co., Inc.*, 440 U.S. 205, 214 (1979). Significantly, *Royal Drug* did not involve a Rule of Reason analysis at all. Rather, the question before this Court was whether certain "Pharmacy Agreements" were immune from antitrust scrutiny by virtue of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1013, which exempts from Section 1 of the Sherman Act the state-regulated business of insurance.[4] In determing whether the Pharmacy Agreements constituted the "business of insurance," this Court looked to whether they involved "any underwriting or spreading of risk" or were "merely arrangements for the purchase of goods and services by Blue Shield." *Id.* at 214.

The Court concluded that, as "arrangements for the purchase of goods and services," the Pharmacy Agreements were not the "business of insurance" and therefore were not immune from Sherman Act scrutiny. The Court did not, however, analyze those Agreements under the Sherman Act. In fact, it explicitly noted that the question whether the Pharmacy Agreements violated the antitrust laws was not presented. *Id.* at 210, n.5. In sum, *Royal Drug* provides no authority for the First Circuit's conclusion that under Section 1 of the Sherman Act, Blue Shield's supposed status as a buyer obviates the need for a searching inquiry into the competitive significance of its conduct.

[4] Under the Pharmacy Agreements, participating pharmacies agreed to receive as full payment from Blue Shield their actual acquisition cost of a drug, plus a $2 markup. 440 U.S. at 209.

Similarly, the Court of Appeals' reliance on lower court cases is also misplaced. The First Circuit relied primarily on *Quality Auto Body, Inc.* v. *Allstate Insurance Co.*, 660 F.2d 1195, 1203 (7th Cir. 1981), *cert. denied*, 455 U.S. 1020 (1982); *Travelers Insurance Company* v. *Blue Cross of Western Pennsylvania*, 481 F.2d 80, 84 (3rd Cir.), *cert. denied*, 414 U.S. 1093 (1973); and *Medical Arts Pharmacy of Stamford, Inc.* v. *Blue Shield of Connecticut, Inc.*, 518 F. Supp. 1100 (D. Conn. 1981), *aff'd per curiam*, 675 F.2d 502 (2d Cir. 1982). In none of those cases, however, did the courts hold that the agreements at issue were lawful because the insurers were merely purchasers.

Rather, each court applied the Rlue of Reason and concluded that the plaintiffs had failed to prove any anticompetitive effect of the plan beyond a reduction of the provider's profits. *See, e.g., Medical Arts, supra*, 675 F.2d at 505 ("Blue Cross pharmacy agreements are novel restraints with potential procompetitive effects, and therefore must be analyzed under the Rule of Reason.")[5] Thus, the Court of Appeals' rejection of the Rule of Reason analysis in favor of a presumption of validity for the ban on balance billing is without any precedential support whatsoever.

II. BY FAILING TO CONDUCT THE REQUIRED ANALYSIS OF THE COMPETITIVE EFFECTS OF THE BAN ON BALANCE BILLING, THE COURT UPHELD A RESTRAINT VIOLATIVE OF THE ANTITRUST LAWS.

The ban on balance billing suppresses competition by restraining both price and output. *See NCAA, supra*, 104

[5] Indeed, the *Medical Arts* court indicated Blue Cross was more properly characterized as an indemnitor rather than as a purchaser and also indicated that the precise characterization was not important to the proper application of the antitrust laws. 675 F.2d at 505-06.

S.Ct. at 2982. Because Blue Shield's subscribers have no out-of-pocket expense, the ban eliminates any sensitivity to price by these subscribers. Consequently, physicians who would otherwise compete on the basis of price have little incentive to do so. In addition, the ban restrains price competition because a physician may raise his or her charges without any penalty imposed by the market.[6]

Furthermore, the ban has had an adverse effect on output —in terms of both quality of patient care and development of new procedures. The ban discourages competition on the basis of quality because the artificially low pricing does not permit the market to reward superiority in skill, experience, or compassion. Moreover, the record reveals very negative effects on innovation. Specifically, development of new procedures that are highly beneficial to patients is discouraged by Blue Shield's policies.

The anticompetitive effects of the ban are inescapable given Blue Shield's domination of the market and its requirement that physicians participate in the plan if any payment is to be made for their services. Absent Blue Shield's market dominance, physicians would be free to reject Blue Shield's strictures. Alternatively, if non-participating physicians received Blue Shield payments, they could treat subscribers and bill them for the difference between the Blue Shield allowable payment and the physician's actual charge. In either case, there would be competition on the basis of price, quality, service and innovation.

---

[6] Although the ban precludes such an increase from resulting in any immediate gain to the physician, the increase can have long-term benefits because increased charges will raise the "usual" charge screen applicable to an individual physician or the "customary" charge level of physicians in the aggregate, thereby increasing Blue Shield's payments.

In light of Blue Shield's market dominance and payment practices, however, physicians in Massachusetts are forced to accept the ban on balance billing. Thus, competition among physicians on the basis of price and quality is inevitably suppressed. In any event, the First Circuit foreclosed an analysis of the competitive effects of the ban by concluding that, as a buyer, Blue Shield did not impose a restraint at all.

CONCLUSION

For the foregoing reasons, the Petitions for a Writ of Certiorari should be granted.

Respectfully submitted,

Newton N. Minow
Jack R. Bierig
Jeffrey R. Tone
Sidley & Austin
One First National Plaza
Chicago, Illinois 60603
(312) 853-7000

Counsel for Amicus Curiae American Medical Association

Of Counsel:

Kirk B. Johnson
B. J. Anderson
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
(312) 645-5000

February 19, 1985

Jack R. Bierig, Esq.
Sidley & Austin
One First National Plaza
Chicago, IL 60603

Re: *Kartell, et al.* v. *Blue Shield of Massachusetts, Inc.*, et al. (1st Cir.)

Dear Mr. Bierig:

On behalf of Drs. Kartell, Horne and Wilson (the original plaintiffs), I hereby consent to the filing by the American Medical Association of a brief *amicus curiae* supporting the grant of a writ of certiorari in this case.

Yours very truly,

JAMES VAN R. SPRINGER

Enclosure

February 19, 1985

Jack R. Bierig, Esq.
Sidley & Austin
One First National Plaza
Chicago, IL 60603

Re: *Kartell* v. *Blue Shield*
(1st Cir. Nos. 84-1241, 84-1303)

Dear Mr. Bierig:

On behalf of the intervenor-plaintiffs, I hereby consent to the filing by the American Medical Association of a brief *amicus curiae* in support of a petition for certiorari.

Sincerely,

THAYER FREMONT-SMITH